UNITED NATIONS

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Secretariat

ST/IC/1990/39
1 June 1990

INFORMATION CIRCULAR

To: Members of the staff at Headquarters

From: The Controller

Subject: RENEWAL OF THE HEADQUARTERS MEDICAL AND DENTAL INSURANCE PLANS AND ANNUAL ENROLMENT CAMPAIGN, 11-15 JUNE 1990*

General

1. The purpose of this circular is to announce:

(a) The 1990 medical and dental insurance enrolment campaign; and

(b) Changes in the premium rates which will come into effect on 1 July 1990.

Premiums, which are shared between the participants and the Organization, have had to be increased moderately in order to meet the projected costs of the plans resulting from the continuing escalation of medical costs at Headquarters. The new premium rates as well as the percentages of salary pertaining to staff members' contributions to the premiums for the various plans and categories of coverage are set out in annexes I to IV to the present circular.

Annual enrolment campaign

2. All staff members holding appointments of three months or longer (or six months or longer, for dental coverage) under the 100 or 200 series of the Staff Rules, 1/ whose duty station is New York and who are not enrolled in a Headquarters medical/dental insurance plan may enrol during this annual campaign. In addition, those currently enrolled may take the opportunity to review their coverage and change from one plan to another, or change their coverage in respect of the members of their family.

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* Personnel Manual index No. 6170.

3. The medical and dental plans being offered during the June campaign are:

(a) Blue Cross/Aetna Major Medical (Blue Cross/Aetna);

(b) Blue Cross/WrapAround Plus (WrapAround Plus);

(c) Health Insurance Plan of Greater New York, Health Maintenance Organization (HIP/HMO);

(d) Kaiser Foundation Health Plan of the Northeast, Health Maintenance Organization (Kaiser/HMO);

(e) GHI Dental Plan (GHI).

Any change which may occur in regard to the plans being offered will be announced in an amendment to the present circular.

4. For enrolment purposes, applicants will be required to present proof of eligibility from their respective personnel or administrative officers attesting to their current contractual status. Eligible family members may also be enrolled at this time. Interested staff members should carefully review the current status of their family's enrolment, both as to the continued eligibility of children and/or inclusion of those newly eligible or not covered at present.

5. Staff members are strongly urged to obtain medical insurance coverage for themselves and their eligible family members, especially since the high cost of medical care could result in financial hardship for individuals who become ill and/or are injured and have no such coverage.

6. The effective date of insurance coverage for all campaign applications, whether for enrolment, change of plan or change of family coverage, will be 1 July 1990.

Time and place of enrolment

7. The annual enrolment campaign at Headquarters will be held from 11 to 15 June 1990 at the offices of the Insurance Section of the Office of Programme Planning, Budget and Finance, room S-2765, between the hours of 10 a.m. and 5 p.m. STAFF MEMBERS AT HEADQUARTERS MUST COME IN PERSON TO THE INSURANCE SECTION OFFICE TO COMPLETE THE APPLICATION FORM AND OTHER FORMS AS NECESSARY. The staff of the Insurance Section will be available during the designated dates and hours to provide information and answer specific questions regarding the health plans being offered to staff.

8. Staff members are reminded that, except as provided in paragraphs 9 and 14 below, this will be the ONLY opportunity until June 1991 to enrol in the United Nations medical and dental insurance plans. This is also an opportunity to review current medical insurance coverages within or outside the Organization and either enrol in one of the United Nations plans or apply for changes within these plans, as may be necessary or desirable.

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Enrolment between annual campaigns

9. Between annual campaigns, staff members and their family members may be allowed to enrol in the Headquarters medical and dental insurance plans ONLY if at least one of the following events occurs and application for enrolment is made within 31 days thereafter:

(a) In respect of medical insurance coverage, upon receipt of an initial appointment of at least three months' duration at Headquarters under the 100 or 200 series of the Staff Rules;

(b) In respect of dental insurance coverage, upon receipt of an initial appointment of at least six months' duration at Headquarters under the 100 or 200 series of the Staff Rules;

(c) Upon transfer to Headquarters, if insured in another United Nations or specialized agency plan at the time of transfer;

(d) Upon return from special leave without pay but only under the health scheme in which insured prior to taking leave (see para. 15 below);

(e) Upon marriage, birth or legal adoption of a child for coverage of the related family member.

Staff members who can demonstrate that they were on mission or annual or sick leave for the entire duration of the annual campaign may enrol within 31 days of their return to Headquarters.

10. In all cases, the completed application for enrolment or re-enrolment must be certified by the appropriate personnel or administrative officer and received by the Insurance Section within 31 days of the occurrence of the event giving rise to entitlement to enrol. Applications and inquiries with regard to changes relating to such events occurring between campaigns should be directed to the Insurance Section as follows:

Insurance Section
Office of Programme Planning, Budget and Finance
Room S-2765
United Nations Headquarters
New York, N.Y. 10017

11. Applications between enrolment campaigns based on any other circumstances or not received within the 31 days of the event giving rise to eligibility will not be receivable by the Insurance Section and will be returned. In this regard, it should be noted that termination of health insurance coverage under a scheme not offered by the United Nations will in no case give rise to any right on the part of a staff member or family member to immediate enrolment in a United Nations plan. If such termination occurs between annual enrolment campaigns, the staff member must wait until the next campaign to enrol in a United Nations plan. Staff members who for any reason may be uncertain about the continuity of their outside coverage

are urged to consider enrolling in a United Nations scheme during the present campaign.

Cessation of coverage of family members

12. The Insurance Section should be notified immediately of changes in the staff member's family which result in a family member ceasing to be eligible, e.g., a spouse upon divorce or a child reaching the age of 25 years, marrying or taking up full-time employment. The responsibility for initiating the resulting change in coverage (e.g. from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") rests with the staff member. Staff members who wish to discontinue coverage of a family member under a United Nations plan for any other reason may do so at any time, although this is strongly discouraged. Such deletions of family members from coverage should be communicated to the Insurance Section directly. It is in the interest of staff members to notify the Insurance Section promptly whenever changes in coverage occur in order to benefit from any reduction in premium contribution which may result. Any such change will be implemented on the first of the month following receipt of notification. No retroactive adjustments can be made due to failure to provide timely notification of any change to the Insurance Section.

After-service health insurance (ASHI)

13. Staff members are reminded that among the eligibility requirements for after-service health insurance coverage is that staff members must be enrolled in a United Nations scheme at the time of separation from service. A minimum of 5 years of prior coverage in a United Nations or specialized agency health insurance scheme is necessary to qualify for unsubsidized after-service health insurance participation and 10 years of prior coverage for subsidized participation. In both cases, the staff member must be 55 years of age or over as of the date of separation. Full details on the eligibility requirements for after-service health insurance coverage are given in the relevant administrative instructions. 2/ It should also be noted that only family members enrolled with the staff member at the time of separation are eligible for continued coverage under the after-service health insurance programme.

14. After-service participants are also reminded that the restriction set out in paragraph 8 above, to the effect that staff members may switch from one insurance plan to another only during the period of the annual enrolment campaign, does not apply fully to them. As provided in administrative instruction ST/AI/172, an after-service participant may transfer from one United Nations health insurance scheme to another at any time, provided that the Insurance Section receives three months' written notice to enable the adjustment to be effected. This privilege is limited to transfers between medical plans (for example, from the Headquarters Blue Cross/Aetna plan to the Van Breda plan or other United Nations plan, should there be a change in residence within the United States or to another country).

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Staff on special leave without pay (SLWOP)

15. Staff members who are granted special leave without pay are reminded that they may retain coverage for medical and dental insurance during such periods, or may elect to discontinue such coverage for the period of the special leave.

(a) Insurance coverage maintained during special leave without pay. If the staff member decides to retain coverage during the period of special leave without pay, the Insurance Section MUST be informed directly by the staff member of his or her intention at least one month in advance of the commencement of the special leave, in person if at Headquarters, or in writing if stationed away from Headquarters. At that time, the Insurance Section will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage(s) retained (both the staff member's contribution as well as the Organization's share, since no subsidy is payable during such leave);

(b) Insurance dropped while on special leave without pay. Should a staff member decide not to retain insurance coverage(s) while on special leave without pay, no action is required upon commencement of the special leave;

(c) Re-enrolment upon return to duty following special leave without pay. Regardless of whether a staff member has decided to retain or drop insurance coverage(s) during a period of special leave without pay, it is essential that he or she re-enrol in the plan(s) with the Insurance Section upon return to duty, in person if at Headquarters, or in writing if away from Headquarters. This must be done within 31 DAYS OF RETURN TO DUTY. Failure to do so will mean that the staff member will be unable to resume participation in the insurance plan(s) until the following annual enrolment campaign in the month of June.

Insurance plan and benefit changes

16. As of 1 July 1990, there will be four medical/hospitalization plans and one dental plan available to United Nations staff at Headquarters. They are described below. With the single exception of the GHI dental plan, for which there will be no rate increase, all four medical/hospitalization plans will be subject to premium increases of varying magnitude which will come into effect on 1 July 1990.

Blue Cross/Aetna Major Medical (Blue Cross/Aetna)

17. The Blue Cross/Aetna Major Medical (Blue Cross/Aetna) insurance plan offers coverage for hospitalization (through Blue Cross) and surgical and medical expenses, and prescription drugs (through Aetna). Summaries of the benefits of the Blue Cross and Aetna components of the Blue Cross/Aetna plan are set out in annexes V and VI to the present circular, respectively.

(a) Benefits. Under the Blue Cross plan component, a new benefit providing for one mammogram per year for all females over age forty-nine was introduced in 1989. This benefit has now been expanded to provide for the coverage of a mammogram for women, regardless of age, with a past history or family history of

breast cancer, upon the recommendation of a physician. In addition, with or without the recommendation of a physician, coverage will be provided

(i) for one baseline mammogram for women ages 35-39;

(ii) for a mammogram every two years for women ages 40-49, and

(iii) for an annual mammogram for women age 50 and older.

To be fully covered by Blue Cross under the above conditions, the mammogram must be performed in a hospital as either an in-patient or out-patient. Under the Aetna component of the plan, Aetna will reimburse the cost of a mammogram not otherwise covered by Blue Cross without any age or frequency limits. This benefit is subject to the normal deductible and co-payment provisions of the Aetna plan;

(b) Premium. Although the costs of the United Nations Blue Cross/Aetna plan reflect utilization of the plan by its participants, the increases in premium which are required for the rate renewal period commencing 1 July 1990 are quite modest when compared with premium increases for the non-United Nations community in the New York area having similar plan structures. The new premiums are shown in column (1) of annex I to the present circular. The percentages of salary contribution by staff members required to cover the increases are shown in column (1) of annex II to the present circular;

(c) Mandatory second surgical opinion. Staff are reminded that reimbursement in respect of 16 surgical procedures performed on a non-emergency basis require a second surgical opinion and that failure to provide a second opinion, which must be furnished by a physician not associated or in practice with the physician who originally recommended and proposed to perform the surgery, WILL RESULT IN A REDUCTION OF THE REIMBURSEMENT FOR THE SURGERY BY 50 PER CENT. THE STAFF IS URGED ONCE AGAIN TO TAKE NOTE OF THIS REQUIREMENT. A complete listing of the surgical procedures subject to mandatory second opinion is provided in annex VI to the present circular;

(d) Aetna claims. The address to which Aetna claim forms should be sent is as follows:

Aetna Life Insurance Company
Unit 41
3541 Winchester Road
Allentown, Pa. 18195-0513

The customer service number for New York City area residents continues to be (212) 567-6969. AS THE PLAN INCURS A SERVICE CHARGE FOR EACH CLAIM SUBMITTED, PARTICIPANTS ARE URGED NOT TO FILE CLAIMS WITH AETNA UNTIL ONE CLAIM OR A GROUP OF CLAIMS EQUALS OR EXCEEDS THE APPLICABLE ANNUAL DEDUCTIBLE;

(e) Access America. Blue Cross/Aetna subscribers are reminded of the existence of an additional benefit within the Blue Cross component, which was first introduced in 1986. This benefit, called Access America, provides an international travellers' 24-hour hotline assistance programme for obtaining medical care abroad. In addition, in most cases, out-of-pocket expenses for foreign hospital admission and treatment will be eliminated, and claims processing and payments will be settled between the foreign facility and Access America/Empire Blue Cross. Moreover, this service will provide referrals to a world-wide network of physicians, dentists, appropriate medical facilities and pharmacy contacts. In the case of hospitalization, Access America medical staff will contact the staff member's/dependant's local physician in order to monitor the case and services being received abroad.

The Access America hotline telephone/telex numbers are as follows:

1-800-654-1901 - (in the United States, Canada, Puerto Rico and the Virgin Islands)

(202) 463-9662 - collect (from Alaska, Washington, D.C. and all other locations), or

Telex No. 706305 ACCESS WSH (from all locations)

When contacting Access America, be sure to identify yourself as a United Nations participant. Your Access America identification number is as follows:

2065-8-(UN INDEX NUMBER)-00.

(f) Conversion privilege. Participants who cease employment with the United Nations, and are not eligible for after-service benefits, may arrange for medical coverage with Blue Cross and Aetna under an individual contract. The conversion privilege, which is part of the United Nations group contract with both Blue Cross and Aetna, means that the insurer cannot refuse to insure an applicant, and that no certification of medical eligibility is required. THE CONVERSION PRIVILEGE, HOWEVER, DOES NOT MEAN THAT THE SAME INSURANCE PREMIUM RATES OR SCHEDULE OF BENEFITS IN EFFECT FOR THE UNITED NATIONS GROUP POLICY WILL BE OFFERED IN RESPECT OF INDIVIDUAL INSURANCE CONTRACTS. It should be noted, however, that the conversion privilege may be exercised only for separating staff who will continue to reside in the United States as Blue Cross as well as Aetna cannot write individual policies for persons residing abroad. Details concerning conversion to an individual insurance policy, which must be exercised within 31 DAYS OF THE DATE OF SEPARATION, may be obtained from the Insurance Section, room S-2765.

Blue Cross/WrapAround Plus (WrapAround Plus)

18. The WrapAround Plus plan represents a hybrid scheme blending the cost advantages of an HMO with the option of personally choosing a physician, whether a member of the extensive Panel of WrapAround Plus physicians or one of your own choosing, not necessarily a member of the WrapAround Plus scheme. The

hospitalization component is exactly the same as currently offered in conjunction with the Aetna plan, and is described in annex V to the present circular. The major medical component of WrapAround Plus offers two choices of utilization combined in the one plan. These are:

(a) Participating provider utilization. Over 13,000 physicians covering the New York City, Westchester and Long Island areas participate in WrapAround Plus and accept as payment a fee schedule arranged by Blue Cross. These physicians are listed in a directory that is available to Headquarters staff for consultation through the United Nations Insurance Section (room S-2765), the Division of Personnel (Miss Annette Garner), UNDP (room DC1-1876), and the Office of Personnel, UNICEF (room H-434). Participants may also telephone Blue Cross at (212) 949-8090 to verify or obtain the name and address of a participating provider. No deductible or waiting period is required and the participant pays $10 for each office or home visit. Full payment is provided for surgical and medical care in or out of the hospital. Additionally, full maternity and approved nursery care are provided;

(b) Private physician utilization. Should the participant choose to be attended to by a non-participating physician or be referred by the participating physician to a non-participating physician, WrapAround Plus will pay 80 per cent of the reasonable and customary charge after the participant has met a $200 deductible per individual/$500 per family. After $900 of unreimbursed reasonable and customary medical expenses have been paid by the participant in a given year, further expenses will be reimbursed in full (100 per cent in lieu of 80 per cent). Additionally, this component of the plan will pay up to $45 per visit for mental and nervous care, subject to a limit of $3,000 per year. The normal deductible and co-payment requirements do not apply to this benefit;

(c) Access America. Blue Cross WrapAround Plus subscribers also benefit from the Access America facility, which is described in paragraph 17 (e) above.

An outline of the benefits of this plan is provided in annex VII to the present circular. The premiums and percentages of salary contributions by staff applicable as of 1 July 1990 are shown in column (2) of annex I to the present circular and column (2) of annex II to the present circular, respectively.

Health Insurance Plan/Health Maintenance Organization (HIP/HMO)

19. This plan follows the concept of total prepaid group practice hospital and medical care, i.e., there is no out-of-pocket cost to the staff member for covered services at numerous participating medical groups in the Greater New York area, including New Jersey and certain areas in Florida. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. Additionally, prescription drugs and medical appliances are covered in full when obtained through HIP/HMO participating pharmacies and are prescribed by HIP/HMO physicians, or any physician in a covered emergency. Staff members who terminate employment with the United Nations, and who are not eligible for after-service health insurance benefits, may convert to an individual policy

with HIP. Information concerning this conversion privilege is available from HIP upon direct request. Details of the HIP/HMO plan are outlined in annex VIII. The premiums and percentages of salary contributions by staff applicable as of 1 July 1990 are shown in column (1) of annex III and column (1) of annex IV to the present circular, respectively.

Kaiser Foundation Health Plan of the Northeast (Kaiser/HMO)

20. The Kaiser Foundation Health Plan is a health maintenance organization, providing all medical-related services at any one of four health centre locations, accessible to staff members residing in northern Bronx, Westchester County and southern Connecticut as well as hospitalization when authorized by a Kaiser physician. Kaiser health centres accommodate not only physicians' offices but also laboratory, X-ray, pharmacy and mental health services. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. There is no ceiling on the use of authorized services, no deductibles to cover and no insurance forms to complete. The only out-of-pocket cost to the staff member is $2 per prescription when filled at a Kaiser pharmacy. The plan coverage emphasizes early detection of medical problems before they become major illnesses. Staff members who terminate employment with the United Nations, and who are not eligible for after-service health insurance benefits, may convert to an individual policy with Kaiser. Information concerning this conversion privilege is available from Kaiser upon direct request. An outline of the benefits of this plan is provided in annex IX to the present circular. The premiums and percentages of staff contributions applicable as of 1 July 1990 are shown in column (2) of annex III and in column (2) of annex IV to the present circular, respectively.

GHI Dental

21. There will be no premium increase for this plan for the year commencing 1 July 1990. A summarized schedule of benefits is contained in annex X to the present circular. A full schedule of benefits may be obtained either from the Insurance Section or GHI upon request. GHI has issued an updated Directory of Participating Dentists, containing the names, addresses and telephone numbers of a large selection of general dental practitioners, dental specialists, as well as several dental groups located throughout the New York area. Copies of the latest directory are available at the Insurance Section, room S-2765. Staff members who terminate employment with the United Nations, and who are not eligible for after-service health insurance benefits, may convert to an individual policy with GHI. Information concerning this conversion privilege is available from GHI upon direct request. The premiums and percentages of staff contributions applicable as of 1 July 1990 are shown respectively in column (3) of annex I and column (4) of annex II, as well as in column (3) of annex III and column (3) of annex IV to the present circular.

22. Where to address claims and benefit inquiries. Although the staff of the Insurance Section is available to assist staff members in administrative matters concerning participation in the various Headquarters insurance plans, claims

questions should always be taken up directly with the insurance company concerned. The addresses and relevant telephone numbers of the insurance companies are listed in annex XI to the present circular.

Notes

1/ The medical scheme applicable to staff at Headquarters appointed for less than three months or under the 300 series of the Staff Rules is described in information circular ST/IC/86/44 of 15 September 1986.

2/ ST/AI/172, ST/AI/172/Amend.2 and 3 and ST/AI/172/Add.2.

Annex I

BLUE CROSS/AETNA, BLUE CROSS WRAPAROUND PLUS AND GHI DENTAL

HEADQUARTERS MEDICAL AND DENTAL INSURANCE
SCHEDULE OF MONTHLY PREMIUMS

(Effective 1 July 1990)

(United States dollars)

	Blue Cross/Aetna (1)	Blue Cross WrapAround Plus (2)	GHI Dental (3)
Type of coverage			
Staff member only	207.77	157.21	9.81
Staff member and one child	401.58	314.05	31.56
Staff member and spouse	439.53	383.68	23.37
Staff member and two or more eligible family members	501.99	383.68	49.00

Important note: The above premiums represent the total monthly premium for a given category of coverage. The cost of the medical/dental insurance plans at Headquarters is shared between the participants and the Organization. Staff members may determine their exact contribution by multiplying their "medical net" salary (see footnote (a) to annex II) by the related percentage of salary (shown in annex II).

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Annex II

BLUE CROSS/AETNA AND BLUE CROSS WRAPAROUND PLUS AND GHI DENTAL

CONTRIBUTION TO MEDICAL AND DENTAL INSURANCE PREMIUMS
AS A PERCENTAGE OF MONTHLY "MEDICAL NET" SALARY a/

(Effective 1 July 1990)

	Blue Cross/ Aetna (1) %	Blue Cross WrapAround Plus (2) %	GHI Dental with any medical plan b/ (3) %	GHI Dental alone (4) %
Type of coverage				
Staff member only	2.56	1.94	0.14	0.21
Staff member and one child c/	4.23	3.42	0.36	0.53
Staff member and spouse	4.33	3.70	0.27	0.39
Staff member and two or more eligible family members c/	4.82	3.70	0.52	0.76

a/ "Medical net" salary for insurance contribution purposes is calculated as gross salary, less staff assessment, plus language allowance, non-resident's allowance, post adjustment or the variable element of monthly subsistence allowance, as applicable. A staff member's monthly contribution is calculated by multiplying his or her monthly "medical net" salary by the percentage appropriate to his or her type of coverage. Actual contributions, however, are never more than 85 per cent of the corresponding premiums, shown in annexes I and III to the present circular.

b/ These rates for the GHI Dental Insurance Plan are applicable only to staff members who are also enrolled in one of the Headquarters medical insurance plans and consequently pay one of the premiums in columns (1) or (2) of annex I.

c/ A child is eligible for coverage under these schemes until the end of the calendar year in which he or she attains the age of 25, provided that he or she is not married and not in full-time employment. Disabled children may be eligible for continued coverage after age 25.

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Annex III

HIP AND KAISER HEALTH MAINTENANCE ORGANIZATIONS, PLUS GHI DENTAL

HEADQUARTERS MEDICAL AND DENTAL INSURANCE
SCHEDULE OF MONTHLY PREMIUMS

(Effective 1 July 1990)

(United States dollars)

Type of coverage	HIP HMO (1)	KAISER HMO (2)	GHI DENTAL (3)
Staff member only	120.23	134.59	9.81
Staff member and one child	291.84	269.18	31.56
Staff member and spouse	291.84	269.18	23.37
Staff member and two or more eligible family members	356.84	363.39	49.00

Important note: The above premiums represent the total monthly premium for a given category of coverage. The cost of the medical/dental insurance plans at Headquarters is shared between the participants and the Organization. Staff members may determine their exact contribution by multiplying their "medical net" salary (see footnote (a) to annex IV) by the related percentage of salary (shown in annex IV).

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Annex IV

HIP AND KAISER HEALTH MAINTENANCE ORGANIZATIONS, PLUS GHI DENTAL

CONTRIBUTION TO MEDICAL AND DENTAL INSURANCE PREMIUMS
AS A PERCENTAGE OF MONTHLY "MEDICAL NET" SALARY a/

(Effective 1 July 1990)

(United States dollars)

	HIP HMO (1) %	KAISER HMO (2) %	GHI DENTAL (3) %
Type of coverage			
Staff member only	1.49	1.66	0.14 b/ 0.21 c/
Staff member and one child d/	3.13	2.90	0.36 b/ 0.53 c/
Staff member and spouse	3.13	2.90	0.27 b/ 0.39 c/
Staff member and two or more eligible family members d/	3.47	3.42	0.52 b/ 0.76 c/

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a/ "Medical net" salary for insurance contribution purposes is calculated as gross salary, less staff assessment, plus language allowance, non-resident's allowance, post adjustment or the variable element of monthly subsistence allowance, as applicable. A staff member's monthly contribution is calculated by multiplying his or her monthly "medical net" salary by the percentage appropriate to his or her type of coverage. Actual contributions, however, are limited to 85 per cent of the corresponding premiums, shown in annexes I and III to the present circular.

b/ GHI dental with any medical plan; these rates are applicable only to staff members who are enrolled in one of the Headquarters medical insurance plans and consequently pay one of the premiums in columns (1) or (2) of annex III.

c/ GHI dental alone.

d/ A child is eligible for coverage under these schemes until the end of the calendar year in which he or she attains the age of 25, provided that he or she is not married and not in full-time employment. Disabled children may be eligible for continued coverage after age 25.

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Annex V

OUTLINE OF BLUE CROSS HOSPITALIZATION INSURANCE COMPONENT APPLICABLE TO BOTH BLUE CROSS/AETNA AND BLUE CROSS WRAPAROUND PLUS

(See annexes VI and VII for major medical components)

Hospital expenses in any legally constituted hospital for the following:

1. In-patient care

Bed, board and general nursing care;
Other hospital services;
Mental or nervous disorders;
Pulmonary tuberculosis;
Physical therapy and rehabilitation;
Substance abuse rehabilitation;
Maternity care;
Hospice care;
Hemodialysis for kidney failure.

2. Out-patient care

Emergency first aid or minor surgery;
Pre-surgical testing;
Home health care;
Hemodialysis for kidney failure.

3. Three hundred and sixty-five (365) days of care at full cost of bed and board based on semi-private room accommodation. Confinement in a hospital beyond 365 days will be borne by the major medical coverage combined with this hospitalization plan i.e., Aetna or Blue Cross WrapAround Plus.

4. Full cost of other hospital services while an in-patient, e.g., use of operating, cystoscopic and recovery room and equipment, X-ray examinations, laboratory and pathological examinations, prescribed drugs and medicine administered in hospital, etc.

5. Coverage for up to 210 days of in-patient hospice care in a certified hospice or hospital and home care and out-patient services provided by the hospice if the patient has been certified by his or her primary attending physician as having a life expectancy of six (6) months or less.

6. Full cost of out-patient services for emergency treatment as follows:

(i) Emergency first aid during the first visit for treatment of an accidental injury within 72 hours following such injury; or

(ii) Emergency care during the first visit for treatment within 12 hours of the onset of sudden or serious illness; or

(iii) Minor surgery.

Benefits will be provided for up to a total of 30 visits per calendar year.

7. Full cost of out-patient services for pre-surgical testing conducted in the same hospital where surgery is scheduled.

8. Full cost of home care, subject to specific conditions.

9. Full cost of 30 days of hospitalization for substance (alcohol and/or drug) abuse detoxification and rehabilitation; limited to two 30-day benefit periods in a lifetime.

10. Sixty out-patient visits per calendar year for each covered person for the diagnosis and treatment of alcoholism and substance abuse. Twenty of these visits are available for counselling for covered family members of the person with the alcohol or substance abuse problem. These 20 family counselling visits will be available whether or not the person is receiving treatment. All care under this benefit must be provided in a facility with an alcoholism treatment programme certified by the New York State Division of Alcoholism and Alcohol Abuse, or a substance abuse treatment programme certified by the New York State Division of Alcoholism and Alcohol Abuse, or a substance abuse treatment programme certified by the New York State Division of Substance Abuse Services as a medically supervised ambulatory substance abuse programme. Outside New York, the facility must be approved by the Joint Commission on Accreditation of Hospitals. Participants are advised to verify with the facility or with Blue Cross that the institution selected for treatment or counselling is properly certified and recognized by Blue Cross.

11. Full cost of 45 days of in-hospital physiotherapy and rehabilitation.

12. Full cost of 30 days of hospitalization for mental or nervous disorders, which may include detoxification treatment for alcohol or substance abuse.

13. Full cost of in-patient and out-patient services for hemodialysis.

14. Full cost for a mammogram, regardless of age, for women with a past history or family history of breast cancer, upon the recommendation of a physician. In addition, with or without the recommendation of a physician, coverage will be provided (i) for one baseline mammogram for women ages 35-39, (ii) for a mammogram every two years for women ages 40-49, and (iii) for an annual mammogram for women age 50 and older. To be fully covered by Blue Cross under the above conditions, the mammogram must be performed in a hospital on either an in-patient or out-patient basis.

Annex VI

AETNA MAJOR MEDICAL INSURANCE COMPONENT

A. Hospital expenses incurred after exceeding Blue Cross coverage maxima listed in annex V are covered by the Aetna Major Medical component. Covered expenses include charges for semi-private hospital room, board, general nursing care, X-ray and laboratory examination, etc.

B. Other covered medical expenses include:

1. The services of a legally qualified physician.

2. The services of a private duty registered nurse (RN) - other than a nurse who ordinarily resides in the staff member's home or who is a member of the staff member's family or his or her spouse's family. Private nursing services in a hospital are not generally considered necessary unless they are in lieu of intensive care or critical care unit nursing services. The circumstances under which private nursing charges are payable are very rare. If your physician recommends such treatment, please contact the Aetna claim office for guidance.

3. Drugs and medicines obtainable only on a prescription of a legally qualified physician.

4. Diagnostic laboratory and X-ray examinations.

5. X-ray, radium and radioactive isotope therapy.

6. Anaesthetics and oxygen.

7. Rental of durable medical or surgical equipment.

8. Artificial limbs and artificial eyes (eye examinations, eyeglasses and hearing aids are excluded).

9. Professional ambulance service when used to transport the individual from the place of injury resulting from an accident or where stricken by a disease to the first hospital where treatment is given. No other charges in connection with travel will be covered.

10. A maximum of 50 out-patient visits per year to a medical doctor engaged in the practice of psychiatry (and, depending on the state in which the provider is licensed, for the services of a psychologist and psychiatric social worker). The maximum recognized charge per visit will be $60, reimbursable at 80 per cent i.e., $48, with an annual maximum not to exceed $2,400 (50 visits x $48 = $2,400). Provider fees exceeding the $60 per-visit rate will be borne by the participant.

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C. Covered expenses listed under A and B above will be reimbursed at 80 per cent after the application of a calendar-year deductible of $125 per person or $375 per family, provided such expenses fall within the REASONABLE AND CUSTOMARY fee levels established by the insurer for the related medical service or procedure in the area of the doctor's place of business. In any calendar year, after an insured person's total unreimbursed expenses reach $1,000 (and after satisfying the deductible), covered expenses for that person will be reimbursed in full for the rest of that year.

D. Special conditions apply to certain medical procedures for dental and cosmetic surgery, for out-patient psychotherapy and for convalescent facility expenses.

E. Reimbursement will be made for second surgical opinion consultation expenses at 100 per cent after the deductible of $125 per person or $375 per family has been met (please see sect. I below).

F. Coverage for 30 days of hospitalization for substance (alcohol and/or drug) abuse rehabilitation, after the 30-day Blue Cross benefit in annex V, item 9.

G. Sixty out-patient visits per calendar year for the treatment of alcoholism or drug abuse diagnosed by a physician. Of these 60 annual visits, 20 may be utilized for the counselling of the patient's family if directly related to the patient's alcoholism or drug abuse.

H. Unlimited overall lifetime reimbursement benefits.

I. SURGICAL PROCEDURES REQUIRING A SECOND MEDICAL OPINION UNDER THE BLUE CROSS/AETNA INSURANCE SCHEME:

	PROCEDURE	EXPLANATION
1.	Bunionectomy	Removal of bunions
2.	Cholecystectomy	Removal of gall bladder
3.	Dilation and curettage	Dilation of cervix and scraping of uterus
4.	Excision of cataracts	Removal of cataracts
5.	Hemorrhoidectomy	Removal of hemorrhoids
6.	Hernia (inguinal) repair	Repair of hernia in the groin
7.	Hysterectomy	Removal of uterus
8.	Knee surgery	Knee operation
9.	Laminectomy	Removal of part of spine
10.	Mastectomy: partial or complete	Partial or complete removal of breast tissue

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11.	Prostatectomy	Removal of prostate
12.	Septo-rhinoplasty	Nose surgery for functional improvement
13.	Spinal fusion	Surgical welding of spine segments
14.	Tonsillectomy and/or adenoidectomy	Removal of tonsils and/or adenoids
15.	Varicose veins	Removal and tying of varicose veins
16.	Coronary artery bypass	Heart surgery to bypass one or more blocked arteries feeding the heart

J. Coverage for the reasonable and customary charges for mammograms at 80 per cent without any age or frequency limits once the annual deductible has been met.

Annex VII

BLUE CROSS WRAPAROUND PLUS

A. Hospital expenses incurred after exceeding Blue Cross coverage maxima listed in annex V above are covered by the Blue Cross WrapAround Plus component. Covered expenses include charges for semi-private hospital room, board, general nursing care, X-ray and laboratory examination, etc.

B. Other covered expenses under the Blue Cross WrapAround Plus scheme are as follows:

1. Paid surgical and medical care in or out of the hospital when using one of the over 13,000 participating WrapAround Plus plan doctors. (Please consult the Blue Cross WrapAround Plus directory or ask your physicians if they are participating in this new programme.) The benefits under this arrangement include:

(a) When using the services of a participating physician for an office or home visit, only a $10 co-payment a/ per visit is required (no claims to file, no deductibles or additional out-of-pocket expenses to be met when being treated by a participating physician);

(b) Well-baby care visits paid in full (six office visits up to age 1, one annual visit per year up to age 6); these visits are in addition to one in-depth examination performed in the hospital by a physician other than the attending physician who delivered the baby;

(c) Physical therapy, physical medicine or rehabilitation paid in full when administered by a participating physician in the hospital for up to 30 days per calendar year ($10 co-payment applicable when administered in the office);

(d) Diagnostic laboratory and X-ray examinations paid in full ($10 co-payment applicable when administered in the physician's office);

(e) X-ray, radium and radioactive isotope therapy paid in full when performed in the hospital ($10 co-payment when administered in the physician's office);

(f) Anaesthetics and oxygen paid in full when administered by a participating physician in the hospital ($10 co-payment applicable when administered in the physician's office);

(g) Surgical second opinion paid in full when rendered by a choice of physicians designated by Blue Cross (call: (212) 481-2658);

(h) Services of a participating chiropractor are covered (X-rays are included);

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2. When using a non-participating physician, the same benefits as those described above will be provided. However, these will be subject to certain charges and limitations as follows:

(a) Deductible of $200 per individual/$500 per family;

(b) 20 per cent out-of-pocket payments on the first $4,500 of reasonable and customary medical expenses ($900), after which the scheme pays 100 per cent in lieu of 80 per cent of covered expenses incurred in a given calendar year;

3. The following additional benefits are covered subject to the payment of the above and a 20 per cent out-of-pocket payment:

(a) The services of a private duty registered nurse (RN) (other than a nurse who ordinarily resides in the staff member's home or who is a member of the staff member's family or his or her spouse's family) if deemed necessary by the attending physician;

(b) Drugs and medicines obtainable only on the prescription of a legally qualified physician;

(c) Rental of durable medical or surgical equipment;

(d) Artificial limbs and artificial eyes (eye examinations, eyeglasses and hearing aids are excluded);

(e) Professional ambulance service when used to transport the individual from the place of injury resulting from an accident or where stricken by a disease to the first hospital where treatment is given. No other charges in connection with travel will be covered;

C. The payment of out-patient mental and nervous treatment at the rate of up to $45 per visit, with an annual maximum of $3,000. (This benefit is not subject to the above deductibles nor the 20 per cent co-payment.);

D. The maximum lifetime benefit payable to the subscriber AND to each of his or her covered dependants under the major medical portion of this plan will be $1,000,000.

Notes

a/ That portion of the medical expense borne by the subscriber.

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Annex VIII

HIP/HEALTH MAINTENANCE ORGANIZATION PLAN

Type of benefit	HIP/HMO coverage
Hospital services	Covered in full when authorized by HIP/HMO physician.
In-hospital physician's services	Covered in full if rendered by HIP/HMO physician.
Private duty nursing	Covered in full when authorized by HIP/HMO physician or by any physician in a covered emergency.
Skilled nursing facility	No limit on number of days when care is in lieu of hospitalization. Care must be arranged by HIP/HMO physician.
Visits to physician's office/ health centre	Covered in full at any HIP/HMO medical centre or if care is rendered by HIP/HMO physician.
House calls	Covered in full when authorized by HIP/HMO physician or emergency service programme.
Maternity care	No waiting periods. Covered in full when care is rendered by HIP/HMO physician. Pre-natal, post-natal and well-baby check-ups are covered in full.
Preventive care:	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens	Covered in full when care is rendered by a HIP/HMO physician. Eye examinations are covered in full when rendered by a HIP/HMO physician (eyeglasses and hearing aids are excluded).
Mental health services:	
In-patient	Covered in full for 30 days per calendar year for mental or nervous disorders.
Out-patient	HIP/HMO has its own mental health centres which provide psychotherapy and counselling for adults and children with mental or emotional problems. Individual, family or group therapy sessions are provided as long as treatment is effective. Intensive psychotherapy is excluded.

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Type of benefit	HIP/HMO coverage
Alcoholism and substance abuse	
In-patient	Covered in full for up to 30 days in any calendar year in a state-certified alcoholism or substance abuse treatment facility.
Out-patient	Medical services for diagnosis and treatment of alcoholism or substance abuse for a period not to exceed 60 visits in any calendar year. HIP/HMO mental health centres will be used for the out-patient services.
Emergency services:	
In area	HIP/HMO has an emergency service programme that is in operation when your medical group is closed. This provides the HIP/HMO subscriber with a 24-hour, 7-day service.
Out of area	Hospital service: In-patient - covered in full. Out-patient - covered in full, when care is received within 12 hours of onset of illness or within 72 hours (three days) following injury. Doctor services - HIP/HMO pays customary and reasonable non-HIP/HMO physician fees for covered emergency illness or accidental injury.
Prescription drugs and medical appliances	Covered in full when obtained through HIP/HMO participating pharmacies. The drugs and appliances must be prescribed by HIP/HMO physicians, or any physician in a covered emergency.

Annex IX

KAISER FOUNDATION HEALTH PLAN OF THE NORTHEAST (KAISER/HMO)

Type of benefit	Kaiser/HMO coverage
Hospital services	Covered in full when authorized by a Kaiser physician.
In-hospital physician's services	Covered in full if rendered or authorized by a Kaiser physician.
Private duty nursing	Covered in full when considered medically necessary.
Skilled nursing facility	Covered in full for 100 days per contract year when prescribed, arranged and approved by a Kaiser physician.
Visits to physicians' office/health centre	Covered in full at any Kaiser medical centre nation-wide or if rendered by or referred by a Kaiser physician.
House calls	Covered in full for a registered nurse or Kaiser physician when medically necessary. Limited to the service area.
Maternity care	No waiting period. Covered in full when rendered by a Kaiser physician. Pre-natal, post-natal and well-baby check-ups are covered in full.
Preventive care:	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens	Covered in full when rendered or authorized by a Kaiser physician.
Mental health services:	
In-patient	Covered in full for 30 days per contract year.

Type of benefit	Kaiser/HMO coverage
Out-patient	Covered in full at Kaiser Medical Center for short-term evaluation or crisis intervention for visits 1-10 per contract year. Visits 11-20 are covered subject to a 25 per cent co-payment of the Kaiser fee-for-service rate. Visits 21-30 are covered at 50 per cent of the Kaiser fee-for-service rate.
Alcoholism treatment:	
In-patient	Covered in full for detoxification only.
Out-patient	Covered in full up to 60 out-patient visits per calendar year for the diagnosis and treatment of alcoholism.
Emergency services:	
In area	Covered in full for life-threatening conditions for care received in a hospital emergency room. Kaiser must be notified first, if possible, or, if not possible, within 48 hours of treatment.
Out of area	Covered in full for reasonable charges for sudden onset of an illness or accident requiring immediate attention. Kaiser must be notified within 48 hours.
Prescription drugs and medical appliances	$2 co-payment for all prescriptions prescribed by Kaiser physicians and obtained at Kaiser pharmacies. Durable medical equipment is covered in full. Coverage is provided for internal prosthetic devices and for their replacement.

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Annex X

GHI DENTAL INSURANCE PLAN (SPECTRUM) a/

	Maximum allowance $
CROWNS AND INLAYS	
Porcelain jacket	125
3/4 cast gold crown	125
Full cast gold crown	150
with acrylic veneer	175
with porcelain veneer	200
Acrylic or vinyl jacket crown	100
Inlays used as abutments	
Two surfaces	75
Three surfaces	100
Pontics	
Tru-pontic	100
Pontic of other type	100
FILLINGS AND RESTORATIONS	
Silver amalgam	
One surface	10
Two surfaces, same tooth	20
Three or more surfaces, same tooth	25
Composite fillings	
Per filling	15
Maximum per tooth	25
REPAIR OF PROSTHETIC APPLIANCES (Maximum $75 per calendar year)	
Repairing body of broken denture	25
Replacing broken teeth in denture not requiring other repairs:	
First tooth	25
each additional tooth	8
Replacing broken teeth in broken denture, per tooth	8
Reattaching clasp on denture, clasp intact	25
Replacing broken clasp on denture with new clasp	40

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	Maximum allowance $
EXTRACTIONS	
Impacted teeth	
Completely covered by bone	100
Partial bony impaction	75
Soft tissue impaction	50
Difficult extractions requiring bone removal, flap and sutures	35
Routine extraction	15
ORAL SURGERY	
Removal of cyst	50
Alveolectomy, maximum per jaw	50
Excision of tissue for biopsy	
Surgery	20
Report	15
ROOT CANAL THERAPY	
One canal, per tooth	100
Two canals, per tooth	125
Three or more canals per tooth	175
PERIODONTICS	
Per treatment	20
Maximum, five treatments, per calendar year	100
Periodontal surgery per quadrant (five or more teeth)	65
PROSTHETIC APPLIANCES (No replacement or interchange within a five-year period will be made for any appliance originally paid for by GHI.)	
Dentures, full or partial	
Full, permanent, each jaw	275
Partial, bilateral acrylic or comparable base, two or more full clasps and rests, each jaw	150
Partial, bilateral, chrome cobalt alloy, two or more full cast clasps with occlusal rests, acrylic attachments and porcelain or acrylic teeth for each jaw	300
Relining or rebasing, maximum 1 each denture, every 3 years	75

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	Maximum allowance $
ORTHODONTICS (Benefits are available only to eligible children to the end of the calendar year in which they become age 25.)	
Diagnosis and initial orthodontic appliances	200
Active treatment per month of treatment	50
Maximum, 24 months	1 000
Passive treatment, per 6 months of treatment	25
Maximum, 18 months	75
OTHER SERVICES	
Examination and charting, one per calendar year	10
Prophylaxis (cleaning) two per calendar year	
(person under 12)	7
(person 12 or over)	10
14 standard X-rays (full mouth series), one every three years	15
4 bitewing X-rays each calendar year	10

PRE-DETERMINATION AMOUNT

If a course of treatment can reasonably be expected to involve covered dental expenses of $200 or more, a description of the procedures to be performed and an estimate of the dentist's charges should be filed with GHI before the course of treatment begins.

Notes

a/ This outline does not cover all services but represents a list of the most commonly used dental services.

Annex XI

INSURANCE CARRIER ADDRESSES AND TELEPHONE NUMBERS
FOR CLAIMS AND BENEFIT INQUIRIES

I. BLUE CROSS HOSPITALIZATION AND BLUE CROSS WRAPAROUND/PLUS

Empire Blue Cross
622 Third Avenue
23rd Floor/Attention: George Haranis
New York, New York 10017

Tel: (212) 490-4141 (For general questions)

(212) 476-3417/3419 (For more specific questions concerning the United Nations Group Plans)

(212) 949-8090 (To verify or obtain a participating provider under the WrapAround Plus major medical plan)

II. AETNA MAJOR MEDICAL PLAN

Aetna Life Insurance Company
Unit 41
3541 Winchester Road
Allentown, Pa. 18195-0513

Tel: (212) 567-6969

III. HIP/HMO

HIP Member Services Department
220 West 58th Street
New York, New York 10019

Tel: 1-800-HIP-TALK (1-800-447-8255)

IV. KAISER/HMO

Kaiser Foundation Health Plan
7-11 South Broadway
White Plains, New York 10601

Tel: (914) 682-0025

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V. GHI DENTAL PLAN

Group Health Incorporated (GHI)
P.O. Box A965, Times Square Station
New York, New York 10108

Tel: (212) 760-6466/6709